STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 03/13/2009

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MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 000	INITIAL COMMENTS Revised report following IDR request conducted on 5/8/09. F279 example deleted. F309 text changes. No changes to scope and severity. An unannounced annual and complaint survey was conducted at this facility which concluded on March 13, 2009. The deficiencies cited in this report are based on observations, interviews, record reviews, review of facility documents and other documentation as indicated. Facility census on the first day of the survey was 164. The survey sample totaled 25, 22 active and 3 closed records. Additionally, there was one extra closed record complaint and there were 13 subsampled residents in which observations and/or focused record reviews were done.	F 000	**The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.** **To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following Plan of Correction. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.**	
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on a group interview and environmental observations, it was determined that the facility failed to post a notice as to the availability of the results of the most recent survey. Findings	F 167	**F 167 Examination of Survey Results** **It is the practice of this facility to allow the resident the right to examine the results of the most recent survey of the facility conducted by Federal or State Surveyors and any plan of correction in effect with respect to the family.** **1. The results of the survey were posted in the front lobby and on the second floor on 3/13/09. A Resident Council meeting was held on 4/21/09 to inform Resident's of location of survey results.** **2. Facility will continue to post where survey results are located. Facility will continue to address availability of survey results at Resident Council Meetings.**	4/24/09 4/24/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Colleen Rodgers — TITLE: NHA — (X6) DATE: 5/14/09

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 include: 1. Results of a Group Interview on 3/4/09 at 10:30 AM revealed that seventeen (17) residents were not aware of the location of the facility's latest survey results. Observations on 3/4/09 during the environmental tours confirmed this finding regarding the lack of posting of a notice of the availability of the survey results.	F 167	**3. The notice as to the availability of survey results will be monitored on a weekly basis by Administrator and or Designee. In-Servicing was done on 3/13/09 regarding F 167, posting of survey results. A Quality Assessment &Assurance monitoring tool was developed to evaluate whether the survey posting is in the designated places.**	4/24/09
F 174 SS=B	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and an individual resident interview, it was determined that the facility failed to provide residents phone access in a private area where calls can be made without being overheard. Findings include: During an individual interview, Resident #21 stated that he had received a few personal phone calls from the phone in the hallway outside of his room. He stated that it was not a very private place to make a phone call as other people in the hallway could overhear one's conversation. Throughout the survey, residents were observed using the telephone in the copy room on the first floor. People went in and out of the room to make copies during these times, and the MDS Coordinator had her office in the same room. When asked if she was usually in the room when residents came in to use the phone she answered, "yes".	F 174	**4. Results of Quality Assessment &Assurance monitoring tool will be reported to the monthly Quality Assessment &Assurance Committee for review and actions, as appropriate. The Quality Assessment & Assurance Committee will determine the need for further audits and or actions.** **F 174 Telephone** **1. Resident #21 no longer resides at the facility. A portable phone was purchased for private use on each unit.**	4/24/09

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F 174	Continued From page 2 Interviews with the unit clerks on the first and second floors revealed that residents who did not have their own phones made calls on the hallway phones or the phones at the nurses station. None of these places provided privacy to residents for making personal phone calls.	F 174	**2. A notice was posted for view in all patient care areas reminding the Residents of the availability of portable phones for privacy in telephone communication.** **A notice of access to portable phones will be included in the admission packet.**	4/24/09
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	**3. The Social Service Director will review resident satisfaction with telephone access quarterly at a resident council meeting.** **Resident concerns will be monitored for complaints regarding telephone access.** **4. The results of this monitoring will be reported to the Quality Assessment &Assurance Committee for review and actions, as appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or actions.** **F225 Staff Treatment of Residents** **It is the practice of this facility to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.**	4/24/09 4/24/09

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F 225	Continued From page 3 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an injury of unknown source and serious injuries for 2 residents (Resident #6 and Resident #20) out of 25 sampled residents was immediately reported to the State Agency, was thoroughly investigated, and that the results of the investigation was reported to the State Agency within 5 working days of the incident. Findings include: Cross refer to F323 example 1a and b. Review of Resident #6's clinical record revealed that on 1/7/09 the resident's attending physician was notified of this resident's complaint of pain on the right foot and this resident "thinks she may have injured while on the stand-up lift". However, review of the facility's investigation lacked documented evidence of a thorough investigation that included interviews of resident/staff that were involved in the transfer/care of this resident using the stand up lift to identify if proper procedures had been followed. Additionally, review of the facility's undated Investigative Report Summary for Resident #6 stated, "Pt. is alert and oriented x3, can articulate if injury occurred. Pt (patient) had pain on bottom of foot when bearing wt only X-ray shows fx (fracture) of uncertain age. Pt. denies trauma which could have caused injury". Review of the	F 225	**It's the practice of the facility that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.** **It is the practice of the facility to maintain evidence that all alleged violations are thoroughly investigated and the practice of the facility to prevent further potential abuse while the investigations are in process.** **It is the practice of the facility to report the results of all investigations to the administrator or his designated representative and to other officials in accordance with State law with 5 working days of the incident and if the alleged violation is verified appropriate corrective action is taken.**	

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F 225	Continued From page 4 facility's Incident Report revealed that Nurse #5 immediately notified the physician and the family but lacked documentation that the incident was immediately reported to the administration. Consequently, review of the facility's "unknown source" incident report provided to the surveyor, revealed that the incident's initial report submission combined with the 5-day follow-up was reported to the State Agency, the DLTCRP on 1/29/09, 22 days after the noted incident. During the informational discussion with the Administrative personnel on 3/13/09, it was revealed that Administrator and DON were not immediately notified and were not aware of this incident in a timely manner. 2. Resident # 20 had diagnoses that included Alzheimer's Disease and anxiety. A nurse's note dated 3/3/09 at 5:17 PM stated, "CNA (CNA#2) alerted nurse that resident was lying on back on the floor with body on fall mat and head on the floor. Laceration to left side of head noted with bleeding. CNA stated "While I was changing (Resident #20), I rolled her on her side and the bed moved and (Resident #20) fell to the floor, possibly hitting her head on the bed side table wheel". Resident #20 was sent to the hospital emergency room for treatment and evaluation. According to the hospital's Radiology Report (CT of the Brain/head)/impression, Resident #20 sustained an "Acute subdural hematoma." Interview with Nurse # 6 (who wrote this nurse's note) on 3/10/09 at 4:15 PM, she stated that CNA #2 said that the bed moved slightly and Nurse #6 confirmed that she wrote the incident report dated 3/3/09. Review of this incident report dated 3/3/09	F 225	**1. Resident #6 initial investigation and follow up was submitted to State agency on 1/15/09.** **ADNS and administrator were made aware of the "probable fracture distal fifth metatarsal of uncertain age on 1/15/09 for Resident #6.** **Incident Occurrences along with witness statements will be reviewed in the daily morning meeting. Residents dependent upon staff for transfers that sustain injuries will be reported to the State Agency per Delaware State Regulations.** **2. Nursing in-serviced on the proper guidelines of reporting incidences to the State Agency. Incident Occurrences will be reviewed in morning stand up meeting to evaluate whether the Incident Occurrence is a reportable incident to the state Agency.** **3. Incident Occurrences will be reviewed in the morning meeting for timely submission to the State Agency. Incident Occurrences will be reviewed to evaluate whether the Administrative Director of Nursing and or Administrator has been notified, if applicable, of a reportable incident.** **4. Results of the Incident Occurrence will be reviewed at the monthly Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will determine the need for further actions.**	4/24/09 4/24/09 4/24/09 4/24/09

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F 225	Continued From page 5 did not address exactly CNA #2's statement as per nurse's note, that is, that the bed moved. Review of the facility's incident report and result of the investigation dated 3/9/09 stated, "CNA (CNA#2) stated while turning resident, the land strip (floor mat) moved from under feet causing her to loose her balance", contrary to her statement to Nurse #6 as written on the nurse's note, that the "bed moved". The statement obtained by the facility from CNA #2 on 3/9/09 during their investigation stated that her "feet were on the mat and I slipped backward and lost my balance and she fell from the bed".The facility's recommendation for preventing similar accidents was to "Maintain distance of bedside table from bed". In an interview with CNA #2 on 3/11/09 at 3:35 PM, it was revealed that Resident #20 was in bed. CNA#2 was reaching to turn the Resident #20 towards her, CNA #2's feet were at the edge of the floor mat and caused the mat to move backward. CNA #2 "lost her balance a little bit", "lost grip on resident and fell". This additional information on why the floor mat moved was not documented in the facility's investigation report The facility's investigation report lacked clear and adequate information as to what caused the incident. The facility failed to ensure that this incident was thoroughly investigated.	F 225	**1. The nurse was in-serviced on the principles and guidelines of documentation in regards to Incident Reporting, obtaining witness statements and accurate documentation in nurse's notes** **2. Incident Occurrences and witness statements are reviewed by the Administrative Director of Nursing and or designee for thoroughness in the morning meeting.** **3. Nursing was in-services on the principles and guidelines of documentation related to Incident Reporting and accuracy of witness statements and nurse's notes. The Certified Nursing Assistant was in-serviced on the reporting of accurate details if involved in an incident occurrence. Incident Occurrences will be reviewed in the daily morning meeting. Falls are reviewed in the morning meeting and will be re-enacted if applicable to evaluate whether proper documentation of the witness statement was obtained.** **4. The Results of Incident Occurrences monitoring will be brought to facilities Quality Assessment &Assurance Committee for review and actions, as appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or action plans.**	4/24/09 4/24/09 4/24/09 4/24/09
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on employee record reviews, and staff interview, it was determined that the facility failed to ensure that six (6) of twenty-one sampled staff had received annual abuse and neglect training. Findings include: Review of employee files indicated the following: 1. Employee #4 was hired 12/27/2007. There was no evidence that this employee had received abuse and neglect training during the year of 2008. 2. Employee #6 was hired 7/18/1988. There was no evidence that this employee had received abuse and neglect training since 8/10/2005. 3. Employee #7 was hired 8/27/1997. There was no evidence that this employee had received abuse and neglect training since 8/5/2005. 4. Employee #8 was hired 10/10/2006. There was no evidence that this employee had received abuse and neglect training since 11/16/2006. 5. Employee #9 was hired 2/4/2007. There was no evidence that this employee had received abuse and neglect training during the year of 2008. 6. Employee #10 was hired 3/18/2005. There was no evidence that this employee had received abuse and neglect training during the year of 2008. Interview with the Human Resources Manager	F 226	**F226 Staff Treatment of Residents** **It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.** **1. The facility provided annual abuse and neglect training for Employee #4 was completed on 3/12/09. Employee #6 was completed on 4/16/09. Employee #7 was completed on 4/21/09. Employee #8 and #9 was completed on 4/15/09. Employee #10 was completed 3/11/09.** **2. The facility has an on-line mandatory training program to audit compliant/non-compliant reports. The Human Resource Director will audit these reports for compliance with annual abuse/neglect training. The facility on-line training program provides for each personnel the required annual mandatory training. Each employee is required to complete specific annual mandatory training each quarter.** **3. The HR Director will monitor the on-line training compliant/non compliant reports bi-monthly for compliance.**	4/24/09 4/24/09 4/24/09

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F 226	Continued From page 7 confirmed that the Mandatory In-Service online courses are federally mandated and should be conducted annually.	F 226	**4. The results of this monitoring will be reported to the Quality Assessment & Assurance committee for review and actions, as appropriate, The Quality Assessment &Assurance committee will determine the need for further monitoring and/or action plans.**	4/24/09
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that three residents (Residents #1, SS#29, and SS#30) were treated in a dignified manner during meal and snack times. Findings include: 1. Resident #1 had Alzheimer's dementia and was ordered to receive a pureed diet. She required extensive assistance with eating. On 3/4/09 at 10:00 AM, Resident #1 was observed seated in a gerichair in the Arcadia 1 dining room with several other residents while staff distributed snacks. Resident #1 watched as other residents were offered snacks, but she was not offered anything to eat or drink. During an interview with the Unit Manager (UM) on 3/4/09, she stated that all residents are offered a snack in the morning and that residents on pureed diets were offered applesauce or yogurt. She stated that residents who had orders for dietary supplements received them from nursing staff. In another interview with the UM later on 3/4/09,	F 241	**F 241 Dignity** **It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.** **1. Resident #1 receives her am snack at the same time the other residents are eating their am snack. Nursing was in-serviced on 4/15/09 regarding the distribution of am snacks to residents. Resident #SS29 and Resident #SS30 reside on the Arcadia/Dementia Unit. Resident #SS29 was on occupational therapy case load for screening of finger foods and to increase independence with self feeding from 2/13/09 until 3/06/09.** **2. The Activity Assistant will be assisting in Level I dining room with queing and encouragement. The Arcadia Unit Director will be evaluating the residents as their Dementia progresses and their need for more assistance develops. These**	4/24/09 4/24/09

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F 241	Continued From page 8 she stated that Resident #1 received her dietary supplement after the group activity. While the resident received her supplement later, nothing was offered to her while other residents around her were eating. The facility failed to treat Resident #1 in a dignified manner by not offering her a snack at the same time that the other residents around her received food and beverages. 2. An observation was made on 3/5/09 in Arcadia (Alzheimer unit) 1 dining room during lunch time from 12:00 PM through 12:25 PM. This dining room served residents who were able to feed themselves but needed extensive supervision and encouragement. Eighteen residents were observed eating lunch in the dining room with 1 CNA staff assisting residents and/or feeding during the observation. 3. Resident #SS29 and #SS30 were observed eating their meals with their fingers. Resident #SS30 was also observed placing a plastic beverage container of tea on top of her vegetables. The facility failed to ensure that these 3 residents were treated in a dignified manner during meals.	F 241	**Resident's in need of more assistance will be brought to Level II Dining room where more assistanee is available.** **3. A.M. snacks will be distributed to Residents on the Arcadia Unit/Dementia Unit daily at 1000 am. An observation will be done once a week to evaluate delivery of am snacks to Residents. A Dining Room Observation will be done once a week by the Arcadia Unit Director to evaluate whether the Resident's are in need of transferring to Level II Dining Room or are in need of adaptive devices.** **An observation audit tool will be done once a week to evaluate whether Resident's receive their am snacks. A Dining Room Observation Tool Will be done once a week to evaluate the need for a Resident to transfer to Level II Dining Room for increase supervision and to evaluate** **the need for an adaptive device.**	4/24/09
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	**4. The results will be reported at the Quality Assessment &Assurance Committee for review and actions, as appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or action plans.**	4/24/09

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F 279	Continued From page 9 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to develop or revise care plans to meet a residents' medical and nursing needs based on the comprehensive assessment for 1 (Resident #11) out of 25 sampled residents. Findings include: 1. During an interview with Resident #11, on 3/9/09, the resident's upper denture moved up and down in her mouth when she spoke. The resident stated that her bottom denture broke and was repaired a couple of months ago, but the upper denture remained loose despite using adhesive, and stated that they had been that way for about a year. Review of the clinical records revealed that the facility failed to have a care plan in place for Resident #11's dental or oral cavity health. Findings were confirmed with the Unit Manager and Social Service Director on 3/9/09 and Resident #11 was scheduled to receive a new set	F 279	**F 279 Comprehensive Care Plans** **It is the practice of the facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. It is the practice of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. It is the practice of the facility that the care plan describes the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10 (b) (4).** **1. Resident #11 Dentures were relined on 4/13/09. Facility has purchased new dentures for Resident #11. Resident #11's care plan for dental/ oral cavity was developed on 4/17/09.**	4/24/09

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F 279	Continued From page 10 of dentures.	F 279	**2. Resident's with dentures are identified upon admission. Social Service Director will be notified of those Resident's in need of oral dental care and the appropriate dental service will be provided. The care plan for dental/oral cavity will be done as applicable.**	4/24/09
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised for four (Resident #1, Resident #5, Residents #13 and #20) of 25 sampled residents. Findings include: 1. Resident #1 was admitted to the facility with Alzheimer's dementia and anxiety. Resident #1 had a care plan, dated 12/8/09 to address the problem of the resident not wanting	F 280	**3. An audit of Resident's with Dentures will be done to evaluate whether their care plan has been developed and or revised as needed. Director of Care Delivery and or their designated designee will inform administration and or their designated designee of Dental/oral issues in the morning stand up meeting.** **4. The results of the dental/oral cavity audit will be reported to the monthly Quality Assessment &Assurance committee for review and actions, as appropriate. The Quality Assessment &Assurance committee will determine the need for further audits and or actions.**	4/24/09 4/24/09

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F 280	Continued From page 11 to sit down at a table to eat meals. The intervention stated, "Allow resident to eat all meals in merry-walker (an enclosed framed wheeled walker) with wheels locked for safety when standing and sitting during meals." Review of Resident #1's clinical record revealed that she had a fall while in her merry-walker on 1/13/09. An order was written on 1/21/09 to discontinue the use of the merry-walker. Meal observations throughout the survey revealed that Resident #1 ate her meals seated in a gerichair. The facility failed to revise Resident #1's care plan to indicate that the merry-walker had been discontinued due to safety concerns. 2. Resident #13 had diagnoses that included ambulatory dysfunction, cervical cord compression with myelopathy, spinal cord infarction, osteoporosis, paraparesis and history of surgical repair of left hip fracture. According to Resident #13's MDS assessments dated 6/10/08 and 2/18/09, this resident's cognitive skills for daily decision-making were "modified independence-some difficulty in new situations only". Resident #13 had a short term memory problem but did not have a long term memory problem. Resident #13 needed extensive assistance of one person with hygiene and bathing and other activities of daily living, except eating. Review of Resident #13's clinical record revealed that this resident had a fall in the facility on 6/30/08 when the CNA left her "unattended" while in a shower chair washing herself in the tub room/shower stall. Resident #13 slid out of the	F 280	**F 280 Comprehensive Care Plans** **It is the practice of this facility to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility of the resident, and other appropriate staff in disciplines as determined by the resident's needs and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.** **1. Resident #1's care plan was revised on 4/15/09. Resident #13's care plan was revised on 4/15/09 to include the approaches and safety strategies as recommended by occupational therapy. Resident #13's care plan was developed on 4/15/09 for osteoporosis. Resident #20's care plan was revised on 4/15/09. Resident #5's Activities of daily living and fall care plans was revised on 3/10/09. Resident # 20 care plan was revised on 4/15/09 on frequent Skin tears r/t fragile skin to address this approach and other safe transfer techniques.**	4/24/09

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F 280	Continued From page 12 shower chair when she "leaned backward to wipe herself" and sustained skin tear to right buttock and right thumb. The facility established a care plan for Resident #13 on "At risk for falls due to Disease process-paraplegia" dated 11/8/2006 with goals to "Minimize risk for injury r/t (related to) falls". After the resident's fall on 6/30/08, the care plan was reviewed and revised to include the intervention of OT Occupational Therapy (OT) evaluation and treatment per orders" dated 7/1/08. Resident #13 was evaluated by the therapist on 7/2/08 through 7/30/08. "Pt. (patient) S (supervision) with AD (Assistive Device for showering" and "OT has discussed safety in shower and given long handled sponge". Interview with the OTA (Occupational Therapist Assistance) on 3/13/09 at approximately 8:10 AM, revealed that OT had discussed with Resident #13 and nursing staff "how to use proper equipment, sitting position, proper reaching of private area, bathing sponge (long handled), proper use of grab bars, and proper use of towel". OTA confirmed that staff was aware of these approaches and results of the evaluation. However, review of Resident #13's current care plan lacked documentation that it was reviewed and revised to clearly address the approaches and safety strategies as a result of OT's evaluation. Additionally, the care plan did not identify this resident's diagnosis of osteoporosis, that would have placed her at a higher risk for injury during care and injury related to falls. Cross-refer to F309 example 5 3. It was observed on 3/13/09 that Resident #20's wheelchair had towels wrapped around the front	F 280	**2. Currently, the facility has no residents utilizing merry walkers.** **Facility identified other like residents with OT approaches to evaluate whether their recommendations were on the care plans.** **Other like residents who receive Restorative Ambulation Program were identified and the accuracy of their care plans were evaluated.** **3. Facility does not have any residents utilizing merry walkers at this time. If a merry walker is issued the care plan will be developed and reviewed quarterly and revised as needed. Occupational Therapy evaluations and or recommendations will be reviewed at the morning meeting. A restorative ambulation Program will be held weekly to identify those residents on the Program and their current status. Care Plans will be audited at the meeting for accuracy. Restorative ambulation patient's care plans will be revised weekly as needed for participation in the Restorative Ambulation Program.** **OT and PT were in-serviced regarding updating and revising care plans completed on 4/24/09.** **4. Results of audit for care plans in regards to the Ambulation Program will be reported to the Quality Assessment &Assurance Committee for review and actions, as**	4/24/09 4/24/09 4/24/09

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F 280	Continued From page 13 frame of her wheel chair, which had no leg rests attached. The facility failed to revise the current care plan on "Frequent Skin tears r/t fragile skin" to clearly address this approach and other safe transfer techniques. 4. Resident #5 sustained a right distal tibia/fibula fracture after falling at the facility on 12/5/08. A significant change Minimum Data Set (MDS) assessment was completed on 12/17/08 which revealed that walking in room or corridor did not occur. Resident #5 continues to be non weight bearing on the right leg. The Activity of Daily Living (ADL) and Fall care plans with print dates of 12/24/08, both continued to list a restorative walking program on them. In a 3/10/09 interview, Physical Therapist #1 confirmed that Resident #5 was not on a restorative walking program due to being non weight bearing on the right leg. Additionally, Resident #5 was currently receiving physical therapy services. The facility failed to revise the ADL and Fall care plans after Resident #5's right distal tibia/fibula fracture. On 3/10/09, the Unit Manager confirmed that the ADL and Fall care plans were not revised regarding the restorative walking program post fracture.	F 280	**appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or actions.**	
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	**F 309 Quality of Care** **It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.**	

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F 309	Continued From page 14 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that five residents (Residents #2, #8, #15, #20, and #24) out of 25 sampled residents and 2 sub sampled residents (Residents SS#27 and SS#31) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The facility failed to have blood work drawn until it was brought to facility's attention by the surveyor for Resident #2. This was was ordered by the physician four days previously. The facility failed to read step 1 of a PPD (test for tuberculosis) for Resident #8. The facility failed to follow the physician's order to continue wearing a back brace for 6 to 8 more weeks for Resident #15. The facility failed to ensure that Resident #20 was handled carefully during transfers and monitored for potential sources of skin tears. The facility failed to implement a physician's order in a timely manner, resulting in Resident #24 missing 6 doses of an ordered medication. The facility failed to transcribe a medication onto the 3/09 Medication Administration Record (MAR) causing Resident SS#27 to miss 6 doses of a preventative UTI medication along with the correct route of administration. The facility failed to follow a physicians's order, dated 2/24/09, to use a hoyer lift with 2 person assist for Resident SS#31. Findings include: 1. Resident #15 was admitted to the facility on 12/24/08 with diagnoses including an acute	F 309	**1. Resident #15 no longer resides at facility. C.N.A in-serviced on 3/6/09 on the proper transfer procedure regarding Resident #SS31. Resident #2 no longer resides at the facility. Resident #8 no longer resides at the facility. Resident #20's care plan has been reviewed and revised to include no leg rests per family request and pad leg rests pin with towels for prevention of skin tears. Resident #SS 27's Medication Administration Record was updated to include the cranberry capsules to be given twice per day on 3/4/09. On 3/13/09 the medication administration record was clarified with the administration route to be via PEG tube. Resident #24 no longer resides at the facility.**	4/24/09

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F 309	Continued From page 15 compression fracture of the lumbar spine, rib contusion (bruise) and osteoporosis. A physician order, dated 12/24/08 stated, "LFO (lumbar) back brace when OOB (out of bed)". On 2/6/09, Resident #15 went to a follow up appointment with an orthopedist who advised continued bracing for 6 to 8 weeks. A physician's order, dated 2/6/09, was written to "Continue wearing brace for 6 - 8 weeks No further follow up is needed unless a problem arises". Nurses notes (NN) of 2/18/09 revealed, "Pt. (patient) being (sic) weaned off back brace". Again on 2/20/09, the NN revealed, "Pt. is being weaned off the back brace...". Then on 3/5/09, the NN documented, "pt. doing well s (without) back brace." Review of the 3/09 Medication Administration Record (MAR) revealed documentation that Resident #15 did not wear the back brace when out of bed during 11 PM to 7 AM, 7 AM to 3 PM and 3 PM to 11 PM shifts for a total of 21 times from 3/1/09 through dayshift on 3/9/09. The facility failed to follow the physician's order, dated 2/6/09, to continue wearing the back brace for 6 - 8 weeks. On 3/11/09, findings were confirmed by the Unit Manager. 2. Resident SS#31 had diagnoses of Alzheimer's Disease and muscle weakness. An observation at 6 AM on 3/6/09 was made of CNA #3 transferring Resident SS#31 via the hoyer mechanical lift by herself. On 2/24/09, a physician's order stated, " transfer c (with) hoyer lift + 2 person assist". The care	F 309	**2. Physician orders are read in morning stand up meeting with clarification if applicable. An observation was completed on 4/21/09 to evaluate proper transferring of residents with hoyer lifts. Lab logs were reviewed to identify like residents. A facility wide sweep was completed on 3/11/09 to evaluate whether first step PPD's were read as per facilities guidelines. Resident's wheelchairs without leg rests will have their care plans revised to include any safety precautions applied. A weekly audit will be performed to evaluate transcription of physician orders to Medication Administration Record. A weekly audit will be done to evaluate transcription orders including start dates on to medication administration record.** **3, Physician orders will be read in morning stand up meeting. Clarifications of orders will be determined at morning meeting if applicable. An in-service was completed on 4/24/09 regarding the need for two person assist when using the Hoyer Lift. Lab Tracking Logs will be reviewed in morning meeting for evaluation of completion of lab work. A weekly audit will be performed to evaluate whether PPD's are being read as per facilities guidelines. A weekly audit will be performed to determine wheelchair safety and that any new safety**	4/24/09 4/24/09

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F 309	Continued From page 16 plan entitled, "At risk for fall due to cognitive impairment, poor safety awareness..." stated, "Transfer with hoyer lift and 2 person assist" which was also "initiated/created" on 2/24/08. During an interview on 3/6/09, Nurse #1 stated that she was unaware that CNA #3 had transferred Resident SS#31 via hoyer lift by herself on 3/6/09 and stated that, "She knows better". Nurse #1 confirmed the resident was to be transferred via a hoyer lift with 2 person assist. During an interview on 3/10/09, CNA #3 confirmed that she knew that Resident SS#31 was to be transferred via a hoyer lift with 2 person assist but decided to transfer the resident by herself. The facility failed to follow the plan of care regarding hoyer lift transfer with 2 person assist which was confirmed by Nurse #1 on 3/6/09. 3. Resident #2 was admitted to the facility on 1/6/09 for rehabilitation following a fall at home, with multiple diagnoses that included hypertension, epistaxis (profuse nosebleeds) and anemia. After admission to the facility, Resident #2 was sent to the hospital emergency room on three occasions for episodes of epistaxis. After his last visit to the hospital, readmission orders, dated 2/25/09, included an order for a CBC (complete blood count) and BMP (basic metabolic panel) to be drawn on 3/2/09. Review of Resident #2's clinical record on 3/6/09 revealed that the blood had not been drawn for these tests. Nurse #2 confirmed that the lab work had not been done and ordered it STAT (immediately).	F 309	**approaches are documented on the care plan.** **A weekly audit will be done to evaluate whether Physician Orders are transcribed onto medication administration records as ordered. An audit will be done weekly to evaluate administration of medications as ordered by physician.** **4. The results of the audits will be reported to the Quality Assessment &Assurance Committee for review and actions, as appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or actions.**	4/24/09

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F 309	Continued From page 17 The facility failed to follow physician's orders to obtain lab work for Resident #2 resulting in a four day delay and was not acted upon until it was brought to the facility's attention by the surveyor. 4. Resident #8 was admitted to the facility on 2/19/09. Admission orders, dated 2/19/09, revealed an order for a PPD (tuberculin) skin test and if negative to repeat in 7 days. There was no evidence that it was read (site examined for a negative or positive reaction) after it was administered. A second PPD was performed on 3/1/09, without the results of the first test being known. Nurse #2 confirmed these findings. The facility failed to read Resident #8's initial PPD test per physician's orders. 5. Resident #20 had diagnoses that included Alzheimer's Disease with Parkinson's features, hypertension with coronary artery disease and anxiety. According to Resident #20's annual Minimum Data Set (MDS) assessment, dated 7/15/08, her cognitive skills for daily decision-making were "severely impaired-never/rarely made decisions". This resident had "highly impaired vision" and was totally dependent on staff for all her activities of daily living (ADLs). Resident #20 had problems with skin tears or cuts and skin was desensitized to pain or pressure. A nurse's note dated 10/30/08 at 7:00 PM stated, "Pt. while being transferred from w/c (wheelchair) to bed obtained a 2x 3.5 cm skin tear to her lower (L) leg. The flap is intact and steri strips were applied and area covered with telfa foam dressing...". Review of the facility's Incident	F 309		

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F 309	Continued From page 18 Report and result of investigation dated 11/6/08 stated, "CNA said while transferring resident from WC (wheel chair) to bed, resident bumped her leg on WC causing 2.0 cm x 3.5 cm skin tear to (L) leg...She has geri legs ordered and they were in place at time of incident. Reeducated CNA (CNA #2) on transfers." Prior to this incident, the facility initiated a care plan on "Frequent Skin tears r/t fragile skin" dated 9/27/06 (no documented evidence of dates last reviewed). The goal of the care plan was "will have no skin tears through next review". The interventions included "monitor for potential source of skin tears" and "handle carefully during care and transfers". Another care plan was established on 9/22/06 (last reviewed on 9/2/2008) related to "ADL Self Care deficit as evidenced by need for ext. assist with ADLs related to physical limitations, Parkinsons, dementia". The intervention included "Per family request - no leg rests to WC at anytime". 6. After the Medication Pass Observation on 3/4/09, the physician's orders were reviewed to reconcile the medications administered to the residents. Resident # SS27, had a physician's order for Cranberry Caps 450 mg 2 tablets PO BID (by mouth twice a day) dated 2/25/09. Review of the 3/09 MAR revealed that this medication was not transcribed as ordered on the 3/09 MAR. Consequently, Resident #SS27 did not receive 6 doses of the medication as per the physician's order. The medication was resumed on 3/4/09 after this finding was confirmed by the RN unit manager. Additionally, a physician's order dated 3/4/09, clarified that the same Cranberry caps and an antibiotic Amoxicillin were to be	F 309		

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F 309	Continued From page 19 given via PEG tube instead of PO. On 3/13/09 it was revealed that this clarification was not transcribed to the 3/09 MAR as ordered. This finding was confirmed by the RN Unit Supervisor on 3/13/09. 7. Resident #24 was admitted on 6/20/08 with diagnoses that included depression and anxiety. Review of Resident #24's clinical record revealed a physician's order dated 7/23/08 that stated, "Effexor (antidepressant, anxiolytic) 75 mg (milligrams) po (by mouth) daily." Review of the 7/08 MAR (Medication Administration Record) revealed that the medication was not started until 7/29/08 (six days later). Although the order was correctly transcribed to the MAR, there was an arrow drawn through the dates before 7/29/08. Findings were confirmed during an interview on 3/13/09 with the Director of Nursing and the Clinical Service Director. They were unable to state why the physician's order was not followed immediately. It was thought that perhaps due to the small size of the boxes on the MAR, that the "29" was mistakenly read as "23". The facility failed to correctly implement a physician's order resulting in six missed doses. Additionally, this was not picked up on the 24 hour chart check which was dated 7/25/08.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	**F 312 Activites of Daily Living** **It is the practice of the facility that a resident that is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.**	

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F 312	Continued From page 20 Based on observation, it was determined that the facility failed to ensure that 5 subsampled residents (Residents #SS32, #SS34, #SS35, #SS36, #SS37) in Arcadia 1 dining room received supervision and encouragement during meals. These residents were able to feed themselves but they needed supervision and encouragement during the meal. Additionally, based on record review, it was determined that the facility failed to ensure that one subsampled resident (Resident SS#26), received the necessary services to maintain good hygiene. Findings include: Cross-refer to F241 example 2 1. Observations were made on 3/5/09 in Arcadia 1 dining room during lunch time from 12:00 PM through 12:25 PM. This dining room serviced residents who fed themselves but needed extensive supervision and encouragement. Eighteen residents were observed eating lunch in the dining room with 1 CNA (CNA #4) staff assisting residents and/or feeding during the observation. Resident #SS33 folded both hands across her body, stared at the served meal, and did not eat. After calming down Resident #SS29, who kept attempting to get out of his chair, CNA #4 went to Resident #SS33 and started to feed this resident. Resident #SS32 dropped his fork on the floor while eating. At that time, the CNA #4 did not notice the incident as she was busy feeding Resident #SS33. Resident #SS29 wore a helmet, and appeared to be very unsteady, attempted to stand up, then sat down on his chair, bent over the side of his chair, and tried to reach for the fork on the floor. A surveyor intervened, picked up the fork, and handed it to CNA #4. CNA #4 did not	F 312	**1. Resident #SS33 no longer resides at facility. Resident #SS32,#SS34, #SS35,#SS36,#SS37 and Resident #SS29 reside on Arcadia/Dementia Unit. An additional employee has been assigned to the Level I dining room to supervise meals for these residents. Resident #SS26 no longer resides at facility.** **2. The Activity Assistant will be assisting in Level I dining room with queing and encouragement. The Arcadia Unit Director will be evaluating the residents as their Dementia progress and their need for more assistance develops. These Resident's in need of more assistance will be brought to Level II Dining room where more assistance is available. An audit of Certified Nursing Data flow records will be performed to evaluate whether showers or baths are given.** **3. A Dining Room observation audit tool will be done once a week to evaluate the need for a Resident to transfer to Level II Dining Room for increase supervision and to evaluate the need for an adaptive device. Shower sheets will be brought to the facilities morning and afternoon meeting to evaluate whether showers and or baths have been performed. If a resident refuses a shower, and or bath, the nurse interviews and educates the resident and documents this education in the resident's clinical record.**	4/24/09 4/24/09 4/24/09

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F 312	Continued From page 21 have a fork replacement readily available, was distracted by Resident #SS29 who continuously attempted to get out of his chair and wanted to leave the dining room. CNA #4 left Resident #SS33, placed Resident #SS29 in his wheelchair and took him out of the dining room. CNA #4 returned to the dining room, went to the sink and washed Resident #SS32's fork. When she handed the fork back to Resident #SS32, he decided that he didn't want to eat anymore even though his plate was half full. Meantime, CNA #4 went back to Resident SS#33 and continued to feed her. Resident #SS34, #SS35, #SS36 also needed assistance and/or encouragement since they just stared at their plate and would not eat. Resident #SS37 kept walking in and out of the dining room and was not eating her meal. The facility failed to ensure the necessary services were maintained for good nutrition, optimal intake and safety during meals. 2. Resident SS#26 was admitted to the facility on 4/23/08. Review of her initial Minimum Data Set (MDS) assessment, dated 4/30/08, revealed that she required extensive assistance with bathing. According to Resident SS#26's ADL (Activities of Daily Living) worksheets, she was to receive a shower/bath on Tuesdays and Fridays. From her admission to the facility until her discharge on 6/13/08, Resident SS#26 was scheduled to receive 15 showers or baths. Review of her ADL worksheets revealed that she received three showers and refused on four occasions. No evidence could be found in the clinical record that	F 312	**4. The results of the observation tool will be reported to the Quality Assessment & Assurance for review and actions, as appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or actions.**	4/24/09

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F 312	Continued From page 22 she either received or refused showers or baths on the other eight scheduled shower/bath days. The facility failed to provide baths or showers to Resident SS#26 who required extensive assistance with bathing to maintain good personal hygiene.	F 312		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interview, it was determined that the facility failed to ensure that 1 resident, (Resident #6) out of 25 sampled residents received proper care with the use of an assistive device/stand up lift during transfers to prevent avoidable accidents. Resident #6 was transferred with a stand up lift device from the bed to a wheelchair. A CNA failed to ensure that this resident was holding the stand up lift grab bars until the transfer was completed. Resident #6"bumped her right posterior hand and obtained a 3.0 cm x 2.0 cm skin tear. Additionally, during a stand up lift transfer observation of Resident #6 from the wheelchair to the bed, the CNA failed to ensure that this resident was supported by the support strap around her body during the lifting procedure. In addition, the facility failed to maintain an environment free of accident hazards by usage of	F 323	**F 323 Accidents and Supervision** **It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.**	

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F 323	Continued From page 23 a damaged (splinter) door of resident room # 202. Findings include: 1a. Resident # 6 had diagnoses that included lower extremity edema, obesity, right foot drop and RL Peroneal Nerve Palsy (damaged to the peroneal nerve). According to Resident #6's annual Minimum Data Set (MDS) assessment dated 6/25/08, this resident's cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required". Resident #6 had a short term memory problem but had no long term memory problem. Resident #6 was totally dependent on staff for activities of daily living (ADL), she weighed 224 lbs. and she was lifted mechanically for transfers (stand up lift) with the assistance of one person. Review of Resident #6's clinical record revealed that this resident had a history of sustaining skin tears. On 5/4/08 Resident #6 had sustained a 2.4 cm x 1.4 cm skin tear with scant red drainage from the site on her right posterior hand during transfers when a CNA pulled the rope on the stand up lift and caught the resident's hand. A nurse's note dated 11/16/08, timed 11:45 AM, stated "CNA stated, 'I was helping her grab on to the stand up lift to transfer from her bed to chair, and it just tore (skin tear to Right posterior hand measuring 3.0 cm x 2.0 cm)". According to the facility's result of investigation dated 11/21/08, the CNA failed to ensure that this resident held on to the stand up lift grab bars until transfer was completed. The resident and CNA were educated to have resident hold stand up lift grab bars until transfer was complete in order to avoid skin tears.	F 323	**1. Staff was in-serviced on the use of the lift, completed on 4/24/09. C.N.A. was in-serviced on the different sizes of support straps to be used. The front door to Resident's room #202 was sanded by the Maintenance Department on 3/3/09.** **2. An observation was completed on 3/12/09 to evaluate use of the lift. A facility sweep of Resident Room Doors was completed on 3/3/09.** **3. A weekly observation audit will be done to evaluated proper transfer with stand up lifts including correct size of strap. Environmental rounds will be done monthly to evaluate the laminate on Resident Room Doors.** **4. The results of the observation audit for proper transfer with stand up lifts will be reported at the Quality Assessment & Assurance meeting. The Quality Assessment & Assurance committee will determine the need for further audits and or action plans. The results of the Environmental rounds will be brought to the month Safety Committee. The Safety Committee will determine the need for further audits and or action plans.**	4/24/09 4/24/09 4/24/09 4/24/09

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F 323	Continued From page 24 The facility established a care plan, "At risk for falls due to previous falls/inability to balance self", dated 2/7/07 (last revised on 10/17/08) and the interventions included "Use stand up lift for transfers". In addition, Resident #6's care plans established on 2/8/07 also identified/addressed this resident's "At risk for skin breakdown related to: decreased mobility and incontinence", and "At risk for friction/shearing due to decreased mobility. However, both of these care plans did not reflect dates of last reviews/revisions following these incidents that involved the improper use of a stand up lift. b. Additionally, on 3/6/09 at approximately 10:35 AM an observation of Resident #6's transfer from wheelchair to bed with a stand up lift was performed. The procedure was performed by CNA #1, witnessed by 2 student CNAs and was observed as follows: The sling was positioned around the resident's back, horizontally above the resident's waistline. Resident #6's arms were outside of the sling. The support strap was separated and was brought around the body. When CNA #1 tried to fasten the support strap around the body to fasten the buckles together, CNA #1 discovered that the support strap was too small and it would not fasten around properly. The support strap would help support the resident in the sling during the lifting procedure. CNA #1 confirmed that the support strap was too small and she could not fasten/click it together. CNA #1 did not attempt to replace the support strap and left it unfastened. CNA #1 continued to transfer Resident #6 from the stand up lift to bed without the support strap. The observed stand up lift transfer procedure by CNA #1 without the support strap around the	F 323		

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F 323	Continued From page 25 body was discussed with the RN Unit Manager on 3/6/09. An interview with RN Unit Manager and Assistant Maintenance staff on 3/6/09 confirmed that the sling support came in different sizes and was available on the floor. CNA #1 did not attempt to secure the right support strap and stated that she was not aware that it came in different sizes. 2. Observations and contact on 3/3/209 at 9:15 AM of the damaged laminate of the front door to resident room #202 resulted in a splinter to the surveyor 's hand. An interview with the Maintenance Supervisor confirmed that he also sustained a splinter to his hand and that the door should be sanded.	F 323		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F 329 Unnecessary Drugs** **It is the practice of this facility to have each resident's drug regimen free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration ; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.**	

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F 329	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that one (Resident #21) of 25 sampled residents' drug regimen was free from unnecessary drugs due to inadequate monitoring. The facility failed to obtain a laboratory blood draw for a PT/INR (measure blood coagulation) as ordered by the physician for Resident #21. This test is necessary for residents on Coumadin, (anticoagulant), to monitor for potential adverse consequences and ensure levels are within therapeutic range (usually 2.0 - 3.0 for an INR) Following one missed week, the resident's next INR level was elevated which prompted the physician to hold and then lower the dosage of the medication. Resident #21 was admitted to the facility on 2/6/09 with physician's orders that included Coumadin, 5mg once a day. A physician's order, dated 2/20/09, called for a weekly PT/INR. Review of Resident #21's clinical record on 3/9/09 revealed that his last PT/INR was drawn on 2/23/09. In an interview with the second floor Unit Manager (UM) on 3/10/09, he stated that the resident should have had a PT/INR drawn on 3/2/09, but someone blocked out 2/30/09 on the resident's Medication Administration Record as the next test day and it was missed. Resident #21's next PT/INR was drawn on 3/9/09, two weeks later. The results indicated that the INR was elevated at 5.0. (therapeutic range: 2.0 - 3.0)	F 329	**1. Resident #21 PT/INR was drawn on 3/9/09. Resident #21 no longer resides at facility. Nurses were in-serviced on the PT/INR Flow Records.** **2. A facility sweep was completed on 3/8/09 to evaluate whether PT/INR's were completed as ordered by physician.** **Staff was in-serviced, completed on 4/24/09, regarding PT/INR tracking.** **3. PT/INR Flow Records will be audited in the morning stand up meeting to evaluate blood was drawn as ordered by physician.** **4. Results of audit will be brought to monthly QA &A Committee. The QA &A will determine the need for further audits and action plans.**	4/24/09 4/24/09 4/24/09 4/24/09

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F 329	Continued From page 27 On 3/10/09, a physicians's order was written to, "Hold Coumadin x 2 (doses) then (lower) to 3mg PO (by mouth) Q (every) day." The facility failed to ensure that Resident #21's PT/INR was drawn as scheduled to ensure adequate monitoring of the Coumadin therapy.	F 329		
F 366 SS=D	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that 2 residents (Resident #SS28 and #SS38) who refused meals served were offered substitutes of similar nutritive value, and that were appropriate for their dietary requirements. Additional observations and resident interviews throughout the survey revealed that staff do not routinely offer the daily alternate menu items to residents. Findings include: Review of facility menus posted on 3/3/09 revealed that the lunch menu included open faced turkey sandwich with gravy, mashed potatoes, asparagus spears, iced pumpkin (cake) and the alternate listed was meatballs with gravy and yellow squash. During a lunch observation in the Stratford Dining room on 3/3/09, Resident #SS28 was wheeled to her table by staff at 12:00 PM. It was noted on her meal ticket that her diet was "Renal HP (high protein) carb control and 750 cc fluid restriction	F 366	**F 366 Food** **It is the practice of the facility that each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.** **1. Resident #28 was given her requested grilled cheese sandwich, by the Registered Licensed Dietician, following education about her diet and after offering her a more appropriate alternate. Resident #28 still requested a grill cheese despite above interventions.** **The staff was in-serviced on April 24, 2009 regarding the alternates for therapeutic diets.** **Resident #38 no longer resides at facility.**	4/24/09

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F 366	Continued From page 28 (dialysis). At 12:20 PM, Resident #SS28 was wheeled out of the dining room for a blood sugar accucheck according to staff. Resident #SS28 was wheeled back into the dining room at 12:40 PM. According to Nurse #4 and CNA #5, Resident #SS28 requested a grilled cheese sandwich and Nurse #4 informed the dietitian of this resident's request. Subsequently, the Registered Dietitian (RD) came to the dining room and told Resident #SS28 that a grilled cheese sandwich would be provided because she requested it, even though it was not the appropriate diet for her. However the RD did not offer the alternate renal substitute to the resident. Resident #SS28 was served the grilled cheese sandwich. When the surveyor asked the RD if they had an alternate for a renal diet, she left the dining room to check with the kitchen. Upon her return, the RD stated that the alternate renal diet item was meatballs without the gravy. Interview with Nurse #4 and CNA #5 on 3/3/09 confirmed that they did not offer this resident the alternate meat balls without gravy before asking the dietitian and accommodating this resident's request for a grilled cheese sandwich. The RD confirmed that she was not aware that the alternate renal diet was not offered by Nurse #4 and CNA #5. She confirmed that the alternate renal diet should have been offered first. While Resident #SS28 was eating her grilled cheese sandwich, the RD asked the resident if she liked meatballs without gravy and this resident responded, "yes" and continued to eat the grilled cheese sandwich. Contrary to the interview with the RD and Nurse #4 at survey, the facility subsequently submitted documentation about what the RD actually said.	F 366	**2. Residents are interviewed by the Dietary Representative upon admission for preferences. Residents are made aware that alternates are available to them.** **3. A meal time observation/audit will be done on a weekly basis to evaluate whether residents are being offered the appropriate alternate diet. An in-servcie was done on offering appropriate alternate diets.** **4. Results of meal time observation will be brought to the Quality Assessment &Assurance Committee for review and actions, as appropriate. The Quality Assessment &Assurance Committee will determine the need for further audits and or actions.**	4/24/09 4/24/09 4/24/09

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F 366	Continued From page 29 The facility only saw this situatuion as an opportunity to educate and failed to identify the need to offer alternates to the residents. 2. Additionally, on 3/3/09 during the lunch observation in the Stratford Dining Room, Resident #SS38 refused the asparagus on her plate. The staff removed the asparagus from her plate and left without offering/asking this resident what she would like for a vegetable alternate. During the observation, Resident #SS38 complained to the surveyor that she didn't like the asparagus nor the alternate, yellow squash. A staff serving in the dining room overheard this conversation between the surveyor and Resident #SS38. Subsequently, the staff approached Resident #SS38 and told her that they had a vegetable salad and offered to bring her one if she would rather have that. Resident #SS38 quickly agreed and was immediately served a vegetable salad with French dressing.	F 366		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations with the Food Service Manager on 3/3/2009, it was determined that the facility failed to protect food during preparation,	F 371	**F 371** **It is the practice of this facility to store, prepare, distribute, and serve food under sanitary conditions.** **1. Facility purchased two large drying racks for the plastic domes on 4/17/09. The stack of five steam table pans were removed from circulation and re-washed and dried on 3/3/09.**	4/24/09

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F 371	Continued From page 30 storage and distribution. Findings include: 1. At 7:40 AM, inverted wet plastic domes were stacked on a cart by the food tray line. 2. At 7:55 AM, stack of five (5) steam table pans on the ready-to-use rack were dripping wet. 3. At 8:15 AM, the cook served pancakes with a soiled gloved hand. Tongs were not used. The Food Service Manager confirmed these findings.	F 371	**The Dietary cook removed gloves and washed hands. A new set of gloves were distributed and put on. A clean pair of tongs was given to the cook to serve the pancakes.** **2. The Staff was in-serviced on 4/1/09 on the proper drying procedures for steam table pans and plastic domes. The Staff was in-serviced on 4/1/09 on the need to wear clean gloves and to use tongs as appropriate.**	4|24|09
F 497 SS=B	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to ensure that three (3) of six (6) sampled nursing assistants received the mandatory 12 hours of in-service training per year. (Employees #1 through #3).	F 497	**3. The Food Service Director currently performs daily, weekly and monthly sanitation inspections. The mentioned items will be added to these lists as appropriate. The Food Service Director and Administrator will perform random audits using the weekly sanitation checklist to ensure compliance.** **4. Findings of the random audits will be summarized and reported to the Quality Assessment &Assurance committee for review and actions, as appropriate. The committee will determine the need for further audits and/or actions plans.** **F 497 Regular In-Service Education** **It is the practice of this facility to complete a performance review of every nurse aide at least once every 12 months, and must provide regular**	4|24|09 4|24|09

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	085033	A. BUILDING _____ B. WING _____	C 03/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 497	Continued From page 31 Findings include: 1. Employee #1 was hired 11/4/1996. Review of in-service records revealed a shortage of 4.4 hours of training. 2. Employee #2 was hired 10/28/1997. Review of in-service records revealed a shortage of 1 hour of training. 3. Employee #3 was hired 8/29/1988. Review of in-service records revealed a shortage of 1 hour of training. An interview with the Staff Development Coordinator confirmed these findings.	F 497	**in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairment, also address the care of the cognitively impaired.**	
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain clinical records that were complete and accurately documented for 5 (Residents #5, #9, #11, #12 and #14) out of 25 sampled residents and 1 sub sampled resident	F 514	**1. The facility provided the necessary amount of required training hours to Employees #1, #3 on March 28, 2009. Employee #2 required training hours were completed on 4/13/09.** **2. The facility has an on-line mandatory training program. The HR Director has access to compliant/non-compliant reports. The HR Director will audit these reports for compliance with the required hours of training per employee.** **3. The facility on-line training program provides the minimum require hours of training. The facility also provides additional training per discipline. Each employee is required to complete specific annual mandatory training each quarter.**	4/24/09 4/24/09 4/24/09

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F 514	Continued From page 32 (Resident SS#31). Findings include: 1a. Resident #5 had a care plan, dated 12/15/08, for "Surgical incision... to L (left) medial ankle ..." but the surgical incision was on the right medial ankle. 1b. Resident #5 had a Nurses Note, dated 2/28/09, "continues on tube feeding..." when this resident did not have any PEG/feeding tube. On 3/10/09, both findings were confirmed by the Unit Manager. 2. Resident #9 had a rehab screening after a fall, dated 2/17/02. Resident #9 was admitted to the facility on 12/10/08. On 3/10/09, PT #2 confirmed that she incorrectly documented the year as 2002 rather than 2009. 3a. Resident #12 had a 3/4/09 activities note and a 2/17/09 rehab screening after a fall that were incorrectly documented on her record. Both of these notes should have been documented on another resident's record who had a similar name. On 3/10/09, the Activities Director and PT #1 both confirmed that they incorrectly documented the above notes on the wrong resident's record. 3b. Resident #12 had a discrepancy in the allergies listed. On the front of the record, the 3/09 Physician order sheet (POS), the 3/09 Medication Administration Record (MAR), and the 3/09 Treatment Administration Record (TAR) there were listed 2 medication allergies. Resident #12's current care plans including the Allergy care	F 514	**4. The HR Director will monitor the on-line training compliant/non compliant reports bi-monthly for compliance with the required hours of training per employee. The results of this monitoring will be reported to the Quality Assessment & Assurance committee. The Quality Assessment &Assurance committee will determine the need for further monitoring and/or actions.** **F 514 Clinical Records It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State and progress notes.** **1. Resident #5's care plan was revised to indicate the right medial ankle. The nurse who wrote Resident#5's nurses note was in-serviced on principles and guidelines of documentation. Resident #9's date of PT note was corrected. Resident #12's activity note was placed on the correct chart.**	4/24/09 4/24/09

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F 514	Continued From page 33 plan, dated 1/21/09, listed only one of these medication allergies plus a different medication to which she was allergic. On 3/13/09, Nurse #3 clarified Resident #12's allergies with her physician and family. Nurse #3 confirmed that Resident #12 was allergic to all three medications. Cross refer to F309 example #2. 4. Resident SS#31 had inaccurate documentation on the ADL worksheet for 3/6/09 transfers. CNA #3 was observed on 3/6/09 transferring Resident SS#31 via a hoyer lift with a one person assist but documented that it was a 2 person assist. On 3/10/09, CNA #3 confirmed that she incorrectly documented the transfer as being done with 2 persons when she did it by herself. 5. Resident #14 had a weekly Skin Alteration Record initiated due to "redness/excoriation" to the center of her buttocks beginning 2/12/09. Subsequent weekly Skin Alteration Records specified left buttocks, right superior buttocks and right buttocks being assessed beginning 2/17/09. However, the Skin Alteration Record for the right buttocks area did not list the type of alteration, i.e. redness/excoriation and the date was blank on the assessment done after 2/24/09. Findings were confirmed with the Assistant Director of Nursing on 3/6/09. 6. Resident #11 had a physician's order, dated 3/9/09, for "Miralax Power...via peg tube..." This resident did not have a PEG/feeding tube.	F 514	**Resident #12's Physician order sheet, the 3/09 Medication Administration Record and the 3/09 Treatment Administration Record were updated to include three allergies. Resident #12's care plan for allergies was revised. Resident SS#31 is a hoyer lift and is a two person assist. C.N.A in-serviced on the principles and guidelines of documentation on the Activity of Daily Living worksheet. The documentation Correction (late entry) to the Activity of Daily Living worksheet for 3/6/09 was made. Resident #14 no longer resides at the facility. Resident #14's skin alteration record was corrected (late entry) on 3/6/09 to include the type of skin alteration and the date of 3/6/09 (late entry) was added to the skin alteration record. Resident #11's Physician order sheet was changed to give Miralax Powder by mouth as needed on 3/6/09.** **2. A chart audit will be done weekly by the Director of Care Delivery or their respective designee to evaluate care plans for correct documentation in regards to specific extremities. A weekly audit of nurse's notes for correct documentation will be done by the Director of Care Delivery or their respective designee. A weekly audit of dates of PT screens will be done by the Physical Therapy Director or respective designee to evaluate the correct documentation of dates. A weekly audit of Resident's**	4/24/09

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F 514	Continued From page 34 Findings were confirmed with the Unit Manager on 3/9/09.	F 514	**charts with similar names will be done for correct documentation by the Director of Care Delivery or respective designee. A weekly audit for matching allergies to POS, Medication Administration Record and Treatment Administration Record and care plans will be done by the Director of Care Delivery or their respective designee. A weekly audit of ADL Flow Records for correct documentation related to transfers will be done by the Director of Care Delivery or their respective designee. A weekly audit of weekly skin alteration records for correct dates and skin alteration descriptions will be done by the Director of Care Delivery or their respective designee. A weekly audit of physician order sheets will be done for correct administration routes by the Director of Care Delivery or their respective designee.**	
F 518 SS=E	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on facility documentation and staff interviews, it was determined that the facility failed to ensure that six (6) of twenty-one (21) sampled staff had received annual fire protection training. Findings include: Review of employee files indicated the following: 1. Employee #4 was hired 12/27/2007. There was no evidence that this employee received fire protection training during the year of 2008. 2. Employee #6 was hired 7/18/1988. There was no evidence that this employee received fire protection training during the year of 2008. 3. Employee #7 was hired 8/27/1997. There was no evidence that this employee received fire protection training during the year of 2008. 4. Employee #8 was hired 10/19/2006. There was no evidence that this employee received fire protection training during the year of 2008. 5. Employee #10 was hired 3/18/2005. There	F 518	**3. Nursing staff was in-serviced on the principles and guidelines of documentation, completed on 4/14/09. An alert charting sticker will be placed on the front of the Resident's chart when there are residents with the same or similar names.** **4. Results of the audits will be reported to the Quality Assessment & Assurance Committee for review. The QA &A Committee will determine the need for further audits and or action plans.**	4/24/09 4/24/09

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F 518	Continued From page 35 was no evidence that this employee received fire protection training during the year of 2008. 6. Employee #11 was hired 1/14/2005. There was no evidence that this employee received fire protection training during the year of 2008. Interviews with the Human Resources Manager and Housekeeping Supervisor confirmed that the Mandatory In-Service online courses are federally mandated and should be conducted annually.	F 518	**F518 Disaster and Emergency Preparedness** **It is the practice of this facility to train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.** **1. The facility provided emergency response training to Employees #4 on 3/12/09, Employee #6 on 4/16/09, Employee #7 on 4/21/09, Employee #8 on 4/15/09, Employee #10 and Employee #11 on 3/11/09.** **2. A non compliant report was reviewed. Employees as of 4/21/09 were up to date on emergency preparedness.** **3. The facility utilizes an on-line mandatory training program. A spread sheet was initiated on April 1, 2009 to track employees for their compliant/non-compliant status. The HR Director will audit these reports for compliance with annual fire protection training.** **4. The HR Director will monitor the on-line training compliant/non compliant reports bi-monthly for compliance. The results of this monitoring will be reported to the facility's Quality Assessment & Assurance committee. The committee will determine the need for further monitoring and/or action plans.**	4/24/09 4/24/09 4/24/09 4/24/09

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care – Pike Creek

DATE SURVEY COMPLETED: March 13, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility which concluded on March 13, 2009. The deficiencies cited in this report are based on observations, interviews, record reviews, review of facility documents and other documentation as indicated. Facility census on the first day of the survey was 164. The survey sample totaled 25, 22 active and 3 closed records. Additionally, there was one extra closed record complaint and there were 13 sub-sampled residents in which observations and/or focused record reviews were done.	
3201	**Nursing Home Regulations for Skilled Care**	
3201.6.0	**Services to Residents**	
3201. 6.1	**General Services**	
3201. 6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This regulation is not met as evidenced by:**	

Provider's Signature Mary Collins Rogers Title NHA Date 5/14/09

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	Cross-refer to CMS 2567-L survey date completed 3/13/2009, F309, F312, example #1, #2, #3 and #5, F323 and F329.	Cross reference CMS 2567-L survey date completed 3/13/200, F309, F312, F323, F329 plan of correction
3201. 6.5	**Nursing Administration**	
3201. 6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.**	
	This regulation is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 3/13/2009, F279.	Cross –refer to CMS2567-L survey date completed 3/13/2009, F279 plan of correction
3201. 6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A**	

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	complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment. **This regulation is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/13/2009, F280.	Cross refer to CMS 2567-L survey date completed 3/13/2009 F280 plan of correction
3201. 6.8	**Food Service**	
3201. 6.8.1	**Meals**	
3201. 6.8.1.3	**When residents refuse a meal served, substitutes of similar nutritive value shall be offered.** **This regulation is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/13/2009, F366.	Cross refer to 2567-L survey date completed 3/13/2009 F366
3201. 6.11	**Medications**	
3201. 6.11.1	**Medication Administration**	
3201. 6.11.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in**	

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	accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days. **This regulation is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/13/2009, F309, examples # 6 and #7.	Cross –refer to CMS 2567 –L survey date completed 3/13/2009 F 309 plan of correction
3201. 6.12	**Communicable Diseases**	
3201. 6.12.2	**Specific Requirements for Tuberculosis**	
3201. 6.12.2.6	**Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days.** **This regulation is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/13/2009, F309, example # 4.	Cross refer to CMS 2567 –L survey date completed 3/13/2009 F309 plan of correction

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3201.7.0 3201. 7.5 3201. 7.5.1	Plant, Equipment and Physical Environment Kitchen and Food Storage Areas Facilities shall comply with the Delaware Food Code. This requirement is not met as evidenced by: Based on dietary observations throughout the survey, it was determined that the facility failed to comply with sections 4-901.11 (A) and 3-304.15 of the State of Delaware Regulation Governing Public Eating Places. Findings include: 4-9 PROTECTION OF CLEAN ITEMS 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in ¶ (a) of 21 CFR 178.1010 Sanitizing solutions, before contact with food.	

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	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 3/13/2009, F371, examples #1 and #2. **3-3 PROTECTION FROM CONTAMINATION AFTER RECEIVING** **3-304.15 Gloves, Use Limitation.** **(A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/13/2009, F371, example #3.	Cross-refer to CMS 2567 –L survey date completed 3/13/2009 F371 plan of correction Cross-refer to CMS 2567 –L survey date completed 3/13/2009 F371 plan of correction
3201. 8.0 **3201. 8.4**	**Emergency Preparedness** **The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.**	

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	This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey date completed 3/13/09, F518.	Cross refer cross refer to CMS 2567 –L survey date completed 3/13/2009 F518 plan of correction
3201. 10.0	**Records and Reports**	
3201. 10.1	**There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:**	
3201. 10.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. Telephone number: 1-877-453-0012; fax number: 1-877-264-8516.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 3/13/09, F514.	Cross refer to CMS 2567-L survey date completed 3/13/2009 F514 plan of correction

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	This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey date completed 3/13/09, F225, example #1.	Cross refer to CMS 2567-L survey date completed 3/13/2009 F225 plan of correction
16 Del. C. § 1108	**Posting of inspection summary and other information and public meetings.** **(a) (4) A notice in the form prescribed by the Department stating that information materials relating to the compliance history of the facility are available for inspection at a location in the facility specified by the sign. The notice shall also provide the telephone number to reach the Division to obtain the same information concerning the facility.** **This regulation is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 3/13/2009, F167, example #1.	Cross refer to CMS 2567-L survey date completed 3/13/2009 F167 plan of correction
16 Del. C. § 1121	**Patient's rights** **(11) Every patient and resident may associate and communicate privately and without restriction with persons and groups of the patient's or resident's own choice (on the patient's or resident's own or their initiative) at**	

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	any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage. **This regulation is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 3/13/09, F174.	Cross refer to CMS 2567 –L survey date completed 3/13/2009 F174 plan of correction
16 Del C., §1121,	**Patient's Rights** **It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:** **(1) Every patient and resident shall have the right to receive considerate, respectful, and**	

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	appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality. Cross refer to CMS 2567-L survey date completed 3/13/09, F241.	Cross refer to CMS 2567-L survey date completed 3/13/200 F241
16 Del. C., 1162	**Nursing Staffing** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** Nursing staff must be distributed in order to meet the following minimum shift ratios (per Phase Two): RN/LPN CNA* Day 1:15 residents 1:8 residents Evening 1:23 1:10 Night 1:40 1:20	

NAME OF FACILITY: Manor Care – Pike Creek

DATE SURVEY COMPLETED: March 13, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	* or RN, LPN, or NAIT serving as a CNA. As part of the annual and complaint survey, three weeks of Manor Care at Pike Creek staffing were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The period of 4 through 24 February 2009 was checked. The citations hereon result from that work. **The law was not met as evidenced by:** Manor Care at Pike Creek failed to meet the required 3.28 Daily Care Hours per Resident on the four (4) dates shown below. The care hours per day attained by the facility are parenthesed. 1. Sunday, 8 February 2009 (3.20). 2. Saturday, 14 February 2009 (3.24). 3. Sunday, 15 February 2009 (3.21). 4. Saturday, 21 February 2009 (3.24).	The facility Nursing Administration will review staffing daily after morning meeting to ensure we meet the 3.28 PPD Delaware staffing law commonly known as Eagle La We will review the PPD hours for that day and what the projected PPD hours for next 3 days so we will be in compliance with the 3.28 PPD requirements under Delaware Law. 3/13/09 If the facility falls below 3.28 ppd PRN and/or on call staff will be called into work so we meet the 3.28ppd requirements